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LACK OF EDUCATION IN SOUTH ASIA: THE DEVASTATING LIABILITY TO COMBATING HIV/AIDS

This issues paper was prepared with contribution from Peter Aggleton

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Lack of Education in South Asia:

The Devastating Liability To Combating HIV/AIDS

Introduction

In a recent statement, Peter Piot, the Executive Director of UNAIDS, said “Without education, AIDS will continue its rampant spread. With AIDS out of control, education will be out of reach.” He was talking at the launch of *HIV/AIDS and Education – A Strategic Approach*, a key resource from the UNAIDS Interagency Task Team on Education, and one of the clearest analyses of the relationship between education and HIV/AIDS to date. Endorsed by UNICEF and each of the UNAIDS cosponsors, as well as by bilateral donors such as the US Agency for International Development (USAID), the UK Department for International Development (DFID) and the Swedish International Development Agency (SIDA), this document offers a blueprint for a more considered and strategic regional response.

Central to the argument advanced is the view that good quality education is a powerful weapon against HIV/AIDS. When effectively applied, education has the potential to reduce both societal vulnerability to the epidemic and individual risk. However, the HIV/AIDS pandemic threatens the very infrastructure of education, taking the lives of policy makers, teachers and administrators, and causing untold suffering for children and their families. Consequently, winning the battle against HIV/AIDS is essential in achieving broader educational goals, and working toward these global education goals is in itself a contribution to the battle against HIV/AIDS.

This paper examines the relationship between education and HIV/AIDS with special reference to South Asia. The paper offers an overview of major regional trends in HIV/AIDS. It looks more closely at the links between education and HIV/AIDS as well as lessons learned.¹ The focus here is on global experience to date, although local experience within South Asia is drawn upon where it has been documented. Finally, it considers the implications of HIV/AIDS for education and development within the region – both in relation to the attainment of EFA goals and challenges ahead.

“Only education can empower young people with the knowledge they need to protect themselves from infection. Only education can combat the discrimination that helps perpetuate the pandemic. And only education can help children and young people acquire the knowledge and develop the skills they need to build a better future - the better future that the international community promised every child a decade ago, at the World Summit for Children”.

–Carol Bellamy, Executive Director,
UNICEF Press Centre, Organisation of
African Unity Summit on HIV/AIDS, TB
and other Infectious Diseases, Abuja,
Nigeria, 26 April 2001



HIV/AIDS in South Asia

A rapidly evolving epidemic

Almost 1 million people in Asia and the Pacific acquired HIV in 2002, bringing to an estimated 7.2 million the number of people now living with HIV in this region – a 10% increase since 2001. Current UNAIDS/WHO projections suggest that more than 40% of the estimated new infections between 2002 and 2010 will occur in Asia and the Pacific

Currently, within the region and in many South Asian countries, national HIV prevalence levels as yet remain comparatively low – majority of people in the region are not infected. This offers an important window of opportunity but is little cause for comfort. Twenty years global experience has shown that no country in the world is inherently protected by geography, culture, tradition and religion.

Moreover, in especially populous countries, low national prevalence rates can seriously distort understanding of the epidemic. India's national adult HIV prevalence rate of less than 1%, for example, offers little indication of the serious situation facing the country. In fact, an estimated 3.97 million people were living with HIV at the end of 2001. This is the second highest figure in the world, after South Africa

Elsewhere in the region, in countries such as Bangladesh, Nepal and Sri Lanka, there are rapidly developing local epidemics among those groups most vulnerable to HIV. These include sex workers, injecting drug users, men who have sex with other men, migrant populations and others made vulnerable by economic and social instability. Among injecting drug users, in particular, exceedingly high levels of infection have been reported – upwards of 50% in parts of Myanmar and Nepal, and in Manipur in India.² High rates of needle-sharing have also been documented among drug users in Bangladesh.

If left unchecked, concentrated epidemics affecting only a few individuals can rapidly develop into more generalised ones. Globally, there is increasing infection rates among younger people and in particular among young girls. There are approximately six thousand new infections among young people everyday. Available data from Nepal and India suggest that new infections are occurring increasingly in young people below the age of 29.³ This has serious implications for some



countries in the Asian region in which approximately 54% of its population is below the age of 25.

Evidence from a study in India also indicates that young women who are being infected are mainly, those within the context of a monogamous relationship.⁴ NACO has estimated that of the roughly 27 million pregnancies that occur annually in India at least 100,000 occur in HIV positive women. This is likely to lead to approximately 30,000 infected babies and a further 70,000 children likely to be orphaned as a result of HIV/AIDS.⁵ In some states in India, up to 85% of women attending antenatal clinics are below 20 years of age, indicating something of where the future burden of the epidemic will lie.

Data on impact of AIDS in the region is very limited. Discrimination and stigma though have been widely reported. The NACO/UNICEF study in India on impact found that HIV/AIDS affected children are likely to be withdrawn from schools, are being forced to leave schools or prevented from playing with other children.⁶ Similar acts of discrimination were found during a situation analysis of children affected in Nepal.

In areas hard hit by the epidemic, AIDS is likely to become the leading cause of death among young adults. HIV in India is already one of the two largest and growing causes of death.⁷ Children may become the household's only breadwinners if working-age adults are sick. Exacerbated by gender stereotyping, girls are likely to be kept at home to care for sick relatives, or to do housework. This is serious enough in countries where the gender gap is slight, but in South Asia it compounds existing inequalities in the uptake of schooling by girls. Though the precise numbers of individuals as yet affected within the region is unknown, and more research is needed, there can be no room for complacency in this respect

Some key determinants of the epidemic

Structurally, South Asian countries are remarkably vulnerable to the epidemic. They have been protected so far only by the fact that the epidemic began later in this sub-region than in other parts of the world. In the majority of countries, open discussion of sex and sexuality is taboo. Many display low levels of literacy, extreme gender inequalities, high levels of sexual violence and abuse, denial of sex between men, growing levels of injecting drug use, and human trafficking.

Together with poverty and the economic inequalities that render sex work a lucrative option, these factors systematically render some groups more vulnerable than others. Understanding this structured vulnerability is central to anticipating where the

epidemic will move to next, and what might make for the basis of an effective response.

Sexual transmission is the main mode of HIV infection in all the countries of the region. Contrary to what some may wish to believe, many young people are sexually active from their mid-teenage years onwards and some even earlier. There is evidence from rural Maharashtra in India that among married adolescents, 48% of boys report having had pre-marital sex.⁸ Over 13% of 12-15 year-old boys in 15 Mumbai schools reported having had sexual experiences, over 75% with more than one partner.⁹ Condom use in such relationships remains the exception rather than the norm.

Young people are also prominent among injecting drug users. In India, recent data from a rapid situation assessment study on drug use shows that the age of onset of drug use in various cities ranged from 15 to 18 years.¹⁰ Half of Nepal's 50,000 drug users, including non-injecting drug users, are in the age group of 16-25. Infection patterns, as in other regions, already show the disturbing trend of increased infections in young people below the age of 25.¹¹

Response to the epidemic

All countries in the region have implemented national AIDS Control programmes with focus on awareness campaigns. Despite this, awareness levels remain relatively low in most countries of the region and even where awareness levels are shown to be high as in India misconceptions regarding transmission and prevention abound. Behavioural Sentinel Surveillance Data (2001) in India indicate that though overall 76% had heard of AIDS only 46.8 % in the entire country were aware of the two important methods of prevention. According to the World Bank, over 95% of 15-19 year old Bangladeshis do not know a single method of HIV prevention.

But worth noting is that consistent prevention efforts have resulted in high levels of awareness and knowledge about HIV/AIDS, and the evidence of high condom use among vulnerable populations in certain states. For example, the state of Maharashtra in India is home to a longstanding, generalized epidemic. There, HIV/AIDS responses appear to have resulted in higher levels of awareness and behavioural change among female sex workers, their clients and injecting drug users (66%, 77% and 52% of whom, respectively, said they consistently use condoms—among the highest rates in India)¹². This may have helped prevent the state's epidemic from spinning out of control



Ignorance about the disease and lack of means of protection will condemn many to an early death. Regardless of where they live, and regardless of their age, women and men have a right to the knowledge and means by which to protect themselves and their partners against infection. It should go without saying that education has an important role to play in providing this knowledge and the skills and attitudes within which to put it into practice.

The new push for an ‘education vaccine’ is long overdue, given the power of education to fight HIV/AIDS. Indeed, no country can afford not to act. Those that are worst-affected need to turn back the spread of the epidemic and protect future generations — Uganda and Senegal, Cambodia and Thailand have shown this to be possible. Low-prevalence countries such as many of those in South Asia, on the other hand, need to recognize the speed with which complacency and denial can lead to crisis and equally, the tremendous opportunity for saving of lives and financial resources through prevention. For all countries, two mutually reinforcing objectives are paramount: namely strenuous efforts directed towards the prevention of HIV; accompanied by measures to protect and support the education system.¹³



Education

A powerful means of prevention

Education and HIV/AIDS are intimately linked. Good quality education has been shown to have a variety of positive effects. In Zambia, for instance, surveillance data for Lusaka where there has been a sustained investment in both general and HIV/AIDS-specific forms of education both formal and non-formal, show that the HIV prevalence rate for women aged 15-19 dropped from 27 per cent in 1993 to 15 per cent in 1998. Even more encouraging, the number of HIV positive pregnant girls aged 15-19 has dropped by almost 50% since 1994. The decline was greater among those with secondary and higher levels of education.¹⁴ Further, in India those who cannot read are six times less likely to use a condom during casual sex than are their peers who are educated beyond secondary school.¹⁵

In numerous countries across the world, investment to reduce the 'gender gap' in education is central to the empowerment of women and hence their capacity to influence whether, when, where and how sex takes place.¹⁶ In the absence of a medical vaccine against HIV infection, education therefore offers an effective 'social vaccine' against the epidemic.¹⁷

But how does it achieve these effects? It does so in at least two complementary ways: first by reducing social vulnerability to the epidemic; and second by providing the means for individual risk reduction. ***Tackling both vulnerability and risk is central to prevention success.*** Too often, the focus has been on individuals alone. This fails to recognise the effects of political, legal and religious factors, the media, the family and the community as influences on behaviour. In the majority of South Asian contexts, the family *plays* a significant role in influencing what people think and do.

Vulnerability reduction

Vulnerability to HIV infection occurs when people are limited in their abilities to make and effect free and informed decisions. Vulnerability is influenced by political factors such as the lack of will to respond effectively to the epidemic; economic factors such as poverty; education sector factors such as lack of good quality schooling; contextual factors such as dominant gender roles and expectations, violence and conflict, family breakdown or lack of 'connectedness' to family, school or community; and environmental factors such as absent or inadequate health and social services.



Singly, or in combination, the above factors render some groups more systematically vulnerable to HIV than others. Education in and of itself can reduce vulnerability to HIV/AIDS by increasing literacy and general educational levels, by enhancing a sense of connectedness and security, and by providing children and young people with access to trusted adults. More specifically, it can help eliminate stigma and discrimination, with a view to encouraging greater openness about the epidemic; and promote greater gender equity, with concomitant effects for health, nutrition and the capacity to learn.

But what concrete steps can education systems take to bring about the above goals? Key priorities should lie in:

- Improving management, safety and security in schools to ensure that they offer healthy, protective and gender sensitive learning environments;
- Supporting school health programmes offering gender equitable skills-based health education, appropriate forms of student/teacher interaction, and good quality psychosocial support;
- Creating safer recreational activities in and out of school. Clear norms and guidelines, including codes of practice, need to be developed and promoted to govern adult involvement in youth activities and adult relationships with youth.
- Ensuring greater participation and listening to the voices of young people
- Enabling young people to access the services and resources needed to protect and support against HIV infection. These include access to condoms and to clean needles.
- Strengthening the training of teachers and health workers so as to facilitate the early identification of especially vulnerable children, to promote child protection and safety, and to make appropriate referrals.
- Building livelihood and employment skills and facilitate access to youth-friendly voluntary and confidential HIV counselling and testing services; sexual and reproductive health services; services and support for orphans; and services for substance abuse and injecting drug use.

Central to the success of this work is leadership to empower individuals and communities to take charge and fight back against the epidemic – leadership that recognises the centrality of education to achieving these goals.

Reducing risk

Good quality education about HIV/AIDS is vital for increasing risk reduction behaviours such as abstinence and the delay of first sex; promoting the use of condoms among those who are sexually active; reducing the number of sexual partners; reducing alcohol and substance use; and increasing understanding of the risks associated with injecting illicit drugs.



However, knowledge by itself is not sufficient to protect against HIV/AIDS. What is needed is teaching and learning that helps individuals acquire the understanding, attitudes and skills to take greater responsibility for their own lives, resist negative pressures, minimize harmful behaviours and make healthy life choices.

A good example of holistic approach which integrates education, livelihoods, and reproductive health is the pioneering Better Life Options Program in India. Implemented by the Centre for Development and Population Activities, it uses an empowerment model that offers adolescent girls a combination of life skills, including literacy and vocational training, support for entering and staying in formal school, family life education, and leadership training.. A cross-sectional study covering peri-urban Delhi, rural Madhya Pradesh, and rural Gujarat showed that the Better Life Options Program has a significant impact on participants' economic empowerment (literacy, completion of secondary education, employment, and vocational skills), autonomous decision making (when to marry, how to spend money), reproductive health (visits to health centers, knowledge of HIV/AIDS), self-esteem and confidence, and child survival practices.¹⁸

To be effective, HIV/AIDS education needs to begin early and extend throughout the school years. Unfortunately, some of those most at risk may not be at school, either because they have dropped out or because they never enrolled. Outreach is therefore necessary to include a broader population. Non-formal programmes such as through community based organisations and through the media can ensure that young people are reached both in- and out-of-school. Box 1. gives an example of how edu- entertainment can bring information and contribute to skills building of large numbers of teenagers through the national media and motivate young audiences to engage in healthy behaviours.

BOX 1: Turning into Life Skills – “Chatting with my best friend” in Nepal

“Chatting with my best friend” is the first – and so far only – national radio programme in Nepal which discusses personal issues affecting adolescents in a frank and open manner. It is the most widely listened to radio programme for adolescents in the country, covering life skills issues including sex education, sexual abuse, drug abuse, as well as HIV and other sexually transmitted infections (STI). “Chatting with my best friend” is part of UNICEF-Nepal’s Communication Initiative for Young People and was the result of two years of research, planning and training carried out by UNICEF Nepal country office. It now attracts an estimated 4.5 million adolescent listeners every week.

The programme has developed a process of interactive learning through a mixed media approach. Listeners write about their problems to the programme, which responds in one of two ways: first, by reading and responding to some letters directly on air; and second, by responding to each letter individually, and enclosing booklets and photo novellas on life skills. At the same time, the programme promotes listeners clubs, where young people meet to share the ideas aired in the programme with one another, and to discuss their relevance to their own lives. The clubs also enter into direct correspondence with the producers of the programme giving feedback on particular programmes and reporting their activities, such as training in sexual health and HIV/AIDS protection in collaboration with local support.



Integral to both formal and non-formal efforts is the need for multi-sectoral coordination to enhance education for the long term, especially since the needs of young people are likely to extend beyond what education traditionally offers and beyond what schools can do. For example, the Philippine Out-of-School Children and Youth Development Project has realized positive results in a pilot effort to test some innovative approaches. This project was implemented in the late 1990s, through a partnership between the government, civil society, and the business sector with some 200 local partners, including beneficiaries and their families, providing cash or in-kind support to 26 sub-projects. The project made significant progress in providing learning opportunities to out-of-school children (6- to 14-years old) and young people (15- to 24-years old), or preparing 16- to 24-year-old high school dropouts for employment or self-employment, building the capacity of selected organizations to implement projects for out-of-school youth, and developing a basic life skills competency resource book–teaching guide for high school dropouts who undertake technical or “alternative” education.¹⁹

Good quality education relies on trained and skilled human capacity. Teachers need to be properly trained and supported in their work. They also need to be sensitised to the continuing importance of HIV/AIDS education. Education to prevent HIV infection can be controversial, for educators as well as for the community. Training has therefore got to go beyond basic awareness to include establishing appropriate codes of practice, reviewing personal attitudes and acquiring specific skills for teaching about HIV/AIDS.

Political commitment at the highest level, and most certainly from within ministries of health and education, is vital for success. Despite the prevalence of common misconceptions, such as the view that education about sex and sexuality leads to increased rather than reduced levels of sexual activity,²⁰ community resistance should not be assumed. Parents, religious and traditional leaders are often keen to be better informed and more involved.

It is crucial for each country to identify approaches that will work within its own socio-cultural environment. Only some broad observations are possible here based on experiences across a number of regions since there are also only few evaluation based lessons learned available.

Key priorities for HIV/AIDS prevention education are recommended to include:

- Having in place clear national policies to support this work and to ensure that schools become HIV risk-free environments;
- Preparing and distributing scientifically accurate, culturally appropriate, good-quality teaching and learning materials on HIV/AIDS, life skills and broader communication efforts;



- Preparing and supporting teachers through good quality pre-service and in-service education and training;
- Providing support in introducing the kinds of HIV/AIDS education that are known to work best. Many of these encourage active participation and skills development. Skills-based education can promote behavioural change particularly if presented within a broad based approach to school health and skills for life such as Focusing Resources on effective School Health (FRESH);
- Developing better linkage with health and community services involved in HIV/AIDS work to better cater for the range of needs of young people;
- Strengthened non-formal and community education to reach those who cannot easily be accessed through schools;
- Promoting the appropriate involvement of parents and community leaders;
- Ensuring the involvement of people with HIV/AIDS in the design and implementation of teaching programmes so as to provide access to their life experiences.

Education

A powerful means to combat stigma and discrimination

A major challenge regionally lies in countering the stigma that has surrounded the epidemic. In India, for example, HIV and AIDS-related stigma has been extensively documented at the level of households and communities, within health care systems and in employment. It prevents people from coming forward for testing and for sharing with others their often justified fears about the epidemic.²¹ Stigma also fuels denial – be it by individuals, communities or even the state. It causes the epidemic to be seen as someone else’s problem, and postpones planning with dire consequences to the prevention of infection and mitigation of the epidemic.

When it comes to countering stigma, education has a vital role to play. It can provide the facts by which to challenge misunderstanding and negative stereotypes (e.g. the belief that only the ‘promiscuous’, sex workers and drug users become infected). It can also provide the skills by which young people and others can communicate and negotiate so as to reduce risk. By speaking openly to individuals’ hearts and minds; by helping political leaders and education sector administrators recognise that without proper attention to HIV/AIDS, key educational goals will never be achieved; and by highlighting the value of education as a vaccine for prevention, much can be achieved.

The growing burden of HIV/AIDS on education systems

All over the world, HIV/AIDS is depriving children of their education. The epidemic is killing teachers, administrators and other officials, damaging the infrastructure of education, affecting supply and draining education of its quality. Already in parts of Southern Africa, HIV/AIDS has cut a deadly swathe through the teaching profession.

Children who lost a teacher to AIDS

Country	Primary schoolchildren who lost a teacher to AIDS, 1999
South Africa	100,000
Kenya	95,000
Zimbabwe	86,000
Nigeria	85,000
Uganda	81,000
Zambia	56,000
Malawi	52,000
Ethiopia	51,000
United Republic of Tanzania	49,000
DRCongo	27,000

In some cases, the graduation rate from teacher-training colleges barely replaces the sick and dying workforce.

Teacher deaths due to AIDS in Zambia in 1998 were equivalent to two-thirds of the number of newly qualified teachers, and those who die are often the most skilled and experienced. In the Central African Republic, 85 per cent of teachers who died between 1996 and 1998 were HIV-positive, and they died on average ten years before they were due to retire.²² In Kenya, the death toll among teachers rose from 450 in 1995 to 1,400 in 1999. Côte d'Ivoire and Malawi lose at least one teacher a day.

A recent forum in Cameroon estimated that 10 per cent of teachers could be infected with HIV in the next five years.²³ The forum called for challenges to ignorance, secrecy, denial and the fear of stigmatization and discrimination that still pervade



schools and colleges. Participants wanted HIV/AIDS education to be provided in schools, despite taboos and cultural obstacles. It would be easy to dismiss such responses as unique to one continent, and of little relevance to the countries of South Asia, but for the fact that the same views exist here.

In South Asia, as in Africa in the past, national leaders, education ministers and high level officials have been slow to acknowledge the seriousness of the epidemic or the ability of education to do anything about it. Only a very few have recognised the centrality of education to future HIV/AIDS prevention, and the threats to education systems that HIV/AIDS poses. Such a situation cannot and must not prevail. As teachers and other educators throughout the region begin to fall sick and die, denial and discrimination must be challenged, and steps must be taken to prevent infection and to protect and preserve valuable education systems.

Mitigating the impact of HIV/AIDS on education systems is essential if the supply, quality and demand for education is not to suffer. Concrete measures that can be taken here include:

- Accelerating teacher recruitment through new incentives. Establishing new policies for retaining teachers.
- Facilitating more flexible approaches to part-time work and job-sharing to enable teachers with other commitments (e.g. caring for sick relatives) to continue in employment.
- Reviewing teacher education and training (both pre- and in-service) to ensure that teachers are well prepared to undertake HIV/AIDS education and to meet the special needs of children living with and affected by HIV/AIDS.
- Ensuring that HIV/AIDS is properly reflected in National EFA Plans of Action, and that capacity is built so as to mitigate the effects of the epidemic on the supply, quality and demand for education.
- Continuing to promote access to high quality education for all children, including those in families affected by HIV/AIDS, those living with HIV/AIDS and orphans.
- Improving community awareness of the value and right to education, especially for children affected by HIV/AIDS.
- Ensuring that schools take actions to foster coping and caring for those affected by the pandemic, that are targeted to reach the most affected.

Education for All and HIV/AIDS

Three years ago, UNICEF's report on the State of the World's Children highlighted how the right to education enshrined in the Universal Declaration of Human Rights and the Convention on the Rights of the Child is a matter of morality, justice and economic sense.²⁴ Yet this same report drew attention to significant challenges that exist in South Asia, where about 40 per cent of children entering primary school drop out before reaching grade 5, making this the highest rate of attrition globally.

Gender disparities in education within the region are particularly acute. Nearly two thirds of women in the region are illiterate compared with about one third of men and the gap between girls' and boys' primary enrolment is over 10 percentage points. Significant urban-rural differences exist in school enrolment with rural schools being often remote and poor in quality. Throughout the region, there is an urgent need to upgrade teacher education and training if children and young people are to be provided with good quality education in a safe and secure environment.

A recent review of progress towards meeting the goals of the World Summit for Children²⁵ also points to major regional weaknesses. Against a global decrease in the gender gap in primary school enrolment from 6 percentage points to 3 percentage points, South Asia shows minimal decline. Furthermore, in several countries significant numbers of children are not attending school at all. (See the table below)

TABLE 1: Selected Indicators of Primary Education in South Asia

	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Enrolment	81	53	71	93	70	49	95
Female	83	47	64	92	60	40	95.
Male	80	58	78	93	79	58	95
Survival to G 5	70	86	56	98.30	44	50	96.50
Female	67	86	54	NA	47	44	96
Male	69	86	57.50	NA	43	54	97
Learner Outcomes							
Reading/writing	30	42	NA	88	51	27	61
Mathematics	51	38	NA	40.5	27	70	50

All figures are taken from Synthesis Report *Education for All in South and West Asia: A Decade After Jomtien* (2000)
(See date for the latest year for each parameter)

Such a situation would be serious enough in the absence of HIV/AIDS. Targets set by the year 2000 World Education Forum (WEF), and endorsed regionally, to reduce gender disparities and expand the quantity and quality of education (Appendix 1), are clearly not being met. But in the presence of a rapidly growing regional epidemic the situation is doubly serious. Children and young people are being denied the education that will protect them against infection, and education systems themselves are beginning to show the strain.

The Dakar Framework for Action endorsed by the World Education Forum recognised the need to tackle HIV/AIDS as a matter of extreme urgency. HIV/AIDS and the attainment of EFA goals are intimately connected. Good quality education is a powerful weapon against HIV/AIDS. It can provide the knowledge, skills and understanding that enable individuals and communities to avoid and resist the epidemic's worst effects. Good quality education employs interactive methods which encourage greater participation of children and young people as valuable resources. It can also help reduce some of the fundamental inequalities – of poverty, gender, sexuality, age and ethnicity/race – upon which the epidemic feeds.

But, by threatening the education workforce and by damaging family, community and societal infrastructures, HIV/AIDS undermines the attainment of valued educational goals. It poses major threats to efforts through education to reduce poverty and promote development. It militates against the creation of more innovative, participatory and accountable systems of learning. It threatens progress towards improving the quality of education. And it does little to enhance the status, morale and professionalism of teachers. In short, it turns the clock backwards when it comes to the attainment of the priorities and goals that are central to the EFA framework.

The Dakar Declaration of Commitment made it clear that the heart of EFA activity lies at country level. National EFA Fora have an important role to play in bringing together ministries and civil society organizations to support the achievement of EFA goals. As part of the follow-up to the World Education Forum, countries agreed to prepare comprehensive National EFA Plans by the year 2002.

The Asia and Pacific Regional Framework for Action, prepared in the run-up to Dakar, identified a number of regional priorities. Central among the goals to be aimed for were advances in early childhood care and education; the provision of universal basic education; basic learning and skills programmes; learning achievement; the education of women and girls; and literacy and continuing education.



A February 2000 assessment of progress pointed to 'impressive but inadequate progress' with respect to the attainment of EFA goals.²⁶ Regionally, there has been uneven advance with respect to literacy which was greatest in Bangladesh but very much more limited in Pakistan and Nepal; primary school enrolment was described as 'far from satisfactory'²⁷ while progress was made in Pakistan, Bhutan, Nepal and India; in terms of gender disparities in primary education, Pakistan fared the worst with 60 percent of girls who should have been in school were not; pupil-teacher ratios has worsened in Bhutan, India, Pakistan and Sri Lanka. An over-reliance upon un- or under-qualified teachers was to be observed in many countries.

With respect to gender disparities in education, a regional analysis was conducted in 2001.²⁸ The situation was reported as being worst in Pakistan and best in Bangladesh where parity had been virtually achieved. In India, the interaction between gender and other systems of social stratification caused a problem in some States. Urgent action is needed to attract girls to school and keep them there, and to change family and community attitudes to girls' and women's education. Other issues too require urgent attention. Rapid economic change, together with the changing social expectations, can cause children to be abandoned by their families or sold into sex work. Tens of thousands of homeless young people live on the streets of cities in India, Pakistan and Bangladesh. Among them, the exchange of sex for food and shelter is functional in the absence of other forms of support. Among children sold or trafficked into sex work, HIV/AIDS-related risks may be exceedingly high. Such especially vulnerable young people have particular educational needs, as do child workers who may be cut off from the opportunities provided by education.

The 2001 EFA Monitoring Report is highly cautious in its assessment of progress towards EFA goals throughout Asia in general, and South Asia in particular.²⁹ The report points at best to modest achievement in the provision of good quality primary education; the need for further effort with respect to the need to remedy gender disparities in education; and the need for a doubling of past effort in some countries (e.g. Pakistan) if adult literacy goals are to be met. With respect to the expansion of early childhood care and education and the acquisition of life skills by adolescents and youth, progress overall has been both patchy, and certainly not at the necessary scale to make a difference.

Slow progress too is reported with respect to the setting up of key support processes and mechanisms. While Draft National Action Plans were presented by all countries at a ministerial meeting in April 2001, inadequate NGO involvement was reported in many of these, alongside the lack of participation by major EFA partners. Clearly much remains to be accomplished.



It is within this context that the potential impact of HIV/AIDS needs to be understood. Ultimately, education is among the most powerful tools for promoting development and reducing vulnerability. Recent research has shown that education has a number of important poverty-reducing synergies: one year of schooling for women, for example, lowers fertility by about 10 percent, while one or two years of schooling for mothers reduces child mortality by 15 percent.³⁰ In Kerala, India where literacy is near universal, the infant mortality rate is the lowest in the developing world and the fertility rate is the lowest in India.³¹

But education also offers a ready-made infrastructure for delivering HIV prevention. It is, moreover, highly cost-effective in doing so: first, because the school system brings together students, teachers, parents, and the community; and second, because preventing AIDS through education avoids the major AIDS-related costs of health care and additional education supply.³² In South Asian countries where HIV prevalence is still low, this is particularly important since the large majority of young people are still uninfected. Here, good quality education holds the potential not only to provide children and young people with hope for the future but also the skills and understanding to avoid infection. And the window of opportunity is among children and young people who are largely HIV free.



The way forward

The links between education and HIV/AIDS are fundamental and reciprocal. Education offers a powerful means of preventing HIV/AIDS for the low prevalence countries to prevent new infections and prevent a major epidemic with all its catastrophic consequences. A large scale HIV/AIDS epidemic in the region will seriously threaten education's capacity to deliver. Nowhere is this more pertinent than in relation to the attainment of the fundamental goals for education identified in Education for All, and to which countries throughout the South Asia sub-region are working.

Responding positively to the challenges that lie before us is essential. Doing so in ways that build upon good quality scientific understanding, while catering for regional specificities and needs, is crucial for success. It is important to recognise that in some parts of the region effective progress is being made. A new national behavioural survey conducted in 2001-2002 in India highlights important facets of the country's bid to curtail its epidemic. The survey shows clearly that where interventions have occurred and been sustained, behavioural change has been possible.

Fortunately, and with hindsight, we can learn from experience elsewhere in the world. A range of models which built on the formal education system and also draw on the collective reach of the non-formal and community mechanisms will need to be patch-worked together to ensure all young people are reached. Innovative skills-based programmes, and those training young people themselves as peer educators and counsellors have been used to achieve success elsewhere in the world.³³ Greater sharing of experience within the region is needed to bring existing pilot programmes and interventions to scale.

The frameworks and guidelines that already exist in the Dakar Declaration, in the UN General Assembly Special Session on HIV/AIDS Declaration of Commitment³⁴ and the Millennium Development Goals,³⁵ in the outcome document from of the UN General Assembly Special Session on Children,³⁶ and in the UN system's own *Strategic Framework on Education and HIV/AIDS* provide a blueprint for success. The challenge lies in applying these principles speedily and effectively at country and regional level, and in encouraging education and others ministries to take their role seriously in the struggle against HIV/AIDS.



What then are the challenges for South Asia

Reach all young people immediately with prevention through mobilising and strengthening institutions and through participation of young people. Young people should be a critical target population in low prevalence settings if a society resistant to HIV is to be built in the future. Most adolescents have not as yet established sexual behaviours and risk taking patterns. Their positive behaviours should be supported through information and support services. They are accessible in large numbers in existing institutions or through large groups such as scouts, sports clubs at relatively low cost. They have proved to be a powerful force in their own right as active resources for prevention and care.

Committed and informed leadership will be required if national authorities and the education sector are to act on the basis of what we already know. Beyond this, urgent and timely action is required to build upon existing effective initiatives and to upscale them to reach all in need with education and HIV/AIDS prevention. Specific education sector actions should take the form not of pilot projects, but should be up-scaled to reach all in need. In India, for example, the Government of Andhra Pradesh has introduced school-based HIV/AIDS education to reach 600,000 children in 11,500 schools which will be further scaled up with the coming months to reach 1.3 million children in the state.³⁷

In a region characterised by profound gender disparities, central to success will be efforts to place women and girls top of the list. Strenuous efforts are required to reduce gender disparities in education, and to tackle women and girls' structured vulnerability to HIV/AIDS. While education cannot single-handedly achieve such a goal, it can provide young women with knowledge and skills useful for HIV prevention. It can also raise hopes and aspirations for the future.

Importantly, **policies, guidelines and frameworks for HIV/AIDS prevention and impact mitigation need to be seen as part of the main education menu and not as a mere add-on.** Global experience shows that countries that fail to tackle HIV/AIDS comprehensively with high level leadership and broad community mobilization across sectors make little headway against the epidemic. HIV/AIDS is not only a 'health problem'. Neither is it only of concern to ministries of welfare, labour and planning. HIV/AIDS is a cross-sectoral issue that requires the full and concerted involvement of the education sector if genuine progress is to be made. And let us be frank. Without this involvement, teachers and education administrators will fall sick and die, young people will continue to be infected at ever more alarming rates, and hard sought for educational goals will never be attained.



Ultimately, what is required is a comprehensive and holistic education sector response, not only to prevent new infections, but to combat stigma and discrimination, promote understanding, care and support, and mitigate the impact of the epidemic upon education systems. Such a response should have close linkage both to the work of other sectors and appropriate services.

Such a response is no longer an ‘optional extra’. It is an absolute necessity if the countries of South Asia, in all their diversity, are to avoid the devastation that has already taken place in parts of Africa. Procrastination and denial are our number one enemies. Act now and the worst may yet be avoided. Delay, and decades of progress will be undermined and benefits lost.

Within this context, work to accelerate efforts towards achieving EFA goals can only be welcomed: both because of the importance of education for a nation’s viability, and because of the critical role it can play in preventing HIV/AIDS. In the words of a recent World Bank (2002) report, “Full speed ahead on EFA goals is vital. A general basic education—and not merely instruction on prevention—is among the strongest weapons against the HIV/AIDS epidemic. An urgent, strategic, and education-centred response by countries and their partners is of utmost importance.”

Partnership between education and other sectors is vital for success: not only because HIV/AIDS is a multi-faceted problem; but also because of the useful synergies that derive from working collectively. All over the world, multi-component programmes combining education with other development measures have been found to have greater impact than those that rely upon one approach alone.³⁸

Efforts to mobilise organizations and communities through education are likely to pay rich dividends. It is only when HIV/AIDS is ‘owned’ and responded to locally, that headway can be made. In a region where stigma, denial and discrimination have all too often been the dominant response, the time is ripe for a new and more proactive stance. The education sector, working in partnership with other sectors and groups, has much to offer in this respect.

Focused efforts to reduce risk — among injecting drug users, sex workers, migrants and others — are both important and cost-effective. But by themselves, they cannot halt the epidemic. The educational response to HIV/AIDS must be extended into the wider population, imparting the knowledge, reducing the stigma and discrimination, and providing the services that people need to protect themselves and each other against infection. Most countries still have a window of opportunity in this respect, and education has a vital role to play. But the opportunity to turn back the tide will not last for long. The time for action is now.



Appendix 1

The Dakar Framework for Action, *Education for All: Meeting our Collective Commitments* was adopted by the World Education Forum in Dakar in April 2000.

Participants committed themselves to achieving education for ‘every citizen in every society’.

States agreed to strengthen or develop national plans by 2002 to achieve EFA goals and targets, no later than 2015.

Particular emphasis would be placed on:

- expanding and improving comprehensive early childhood and disadvantaged children;
- ensuring that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete, free and compulsory primary education of good quality;
- ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life-skills programmes;
- achieving a 50 per cent improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults;
- eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015, with a focus on ensuring girls’ full and equal access to and achievement in basic education of good quality;
- improving all aspects of the quality of education and ensuring excellence of all so that recognized and measurable learning outcomes are achieved by all, especially in literacy, numeracy and essential life skills.

A major challenge for India now is that of rapidly **expanding the coverage** of its HIV/AIDS programmes to all vulnerable groups. Flanking that is the broader challenge of **ensuring that the response reaches young, illiterate populations and rural communities, especially women.**



Endnotes

- ¹ Within the space available, this is reasonably succinct, focusing upon major trends. Further country specific information is available from (UNAIDS website)
- ² http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/India_en.pdf
- ³ NACO (2001) Estimation of HIV/AIDS in India. <http://www.naco.nic.in/indianscene/esthiv.htm> and NACO (2000) Combating HIV/AIDS in India. <http://www.naco.nic.in/indianscene/country.htm> See also http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/India_en.pdf and http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/Nepal_en.pdf
- ⁴ UNAIDS and Sociometric Corporation (2001) *Gender Almanac*. <http://www.unaids.org/gender/docs/Gender%20Package/GenderandAIDSalmanac.pdf>
- ⁵ *Feasibility study of administering short AZT interventions among HIV infected mothers to prevent MTCT:MOHFW, NACO, UNICEF, Dec.2001*
- ⁶ Ravi K Verma, et al. The impact of HIV/AIDS related deaths on households and their coping strategies: A study with special reference to children: A case of India. A UNICEF-NACO supported study,2000
- ⁷ National AIDS Control Organisation , 2001
- ⁸ KEM Hospital Research Centre. (1997) *Adolescent Sexuality and Fertility: A survey in rural Maharashtra*. Pune, KEM Hospital Research Centre
- ⁹ Abraham, L. (1998) *Understanding Youth Sexuality: A study of college students in Mumbai*. Mumbai, TISS.
- ¹⁰ Gary Reid & Genevieve Costigan' Revisiting the Hidden Epidemic' A situation Assessment of Drug use in Asia in the context of HIV/AIDS. The Centre for Harm Reduction, the Burnet institute, January 2002
- ¹¹ National AIDS and STD Control Centre, Kathmandu. 2001
- ¹² National Baseline General Population Behavioural Surveillance Survey, 2001. NACO, MOHFW, GOI
- ¹³ Bundy, D. (2002) UNAIDS IATT on Education Press Release. October 22nd
- ¹⁴ Loewenson, R. & Whiteside, A. (2001) *HIV/AIDS: Implications for Poverty Reduction*. United Nations Development Programme Policy Paper. New York, UNDP p. 17.
- ¹⁵ Nationwide Behavioural Surveillance Survey of general population and high-risk groups, 2001–2002, National AIDS Control Organization, India/ORG MARG. Cited in UNAIDS and WHO (2002) *opus cit*.
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- ¹⁸ Education and HIV/AIDS- A window of Hope. 2002 The International bank for Reconstruction and Development/ World Bank
- ¹⁹ Education and HIV/AIDS- A window of Hope. 2002 The International bank for Reconstruction and Development/ World Bank
- ²⁰ Grunseit, A (1997) *Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A Review Update*. Geneva, UNAIDS.
- ²¹ Bharat, S., Aggleton, P. & Tyrer, P. (2001) *India: HIV and AIDS - related Discrimination, Stigmatization and Denial*. Geneva, UNAIDS.
- ²² World Bank (2002) *Education and HIV/AIDS: A window of hope*. Washington, DC., World Bank.
- ²³ UNESCO, 'Education for All' Forum, Yaounde, Cameroon, 22-25 April 2002.
- ²⁴ UNICEF (1999) *The State of the World's Children 1999. Education*. New York, UNICEF.
- ²⁵ UNICEF (2001) *Progress since the World Summit for Children. 1990-2000*. New York, UNICEF.
- ²⁶ Tilak, J. (2000) *Education for All in South and West Asia. A Decade After Jomtien: An Assessment*. South and West Asia Regional Technical Advisory Group and UNESCO, New Delhi.
- ²⁷ Approximately 30% of the children in Nepal and Bhutan, 40 per cent in India and 50% in Pakistan, who should have been in schools were out of school.
- ²⁸ Hasan, S. (2001) *Regional Analysis Report 2001*. Katmandhu, UNICEF ROSA.
- ²⁹ UNESCO (2001) *2001 Monitoring Report on Education for All*. Paris, UNESCO
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- ³¹ UNESCO (1995) *The Education of Girls and Women: Towards a global framework for action*. Paris, UNESCO.
- ³² World Bank (2002) *Education and HIV/AIDS: A window of hope*. Washington, DC., World Bank.
- ³³ <http://www.unaids.org/publications/documents/care/general/peer.pdf>



³⁴ <http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html>

³⁵ <http://www.un.org/millenniumgoals/>

³⁶ UNICEF (2001) *A World Fit for Children*. New York, UNICEF.

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³⁸ See, for example, Bhuiya, A., et al. (2000) Bangladesh: An Intervention Study of Factors underlying Increasing Equity in Child Survival. Ch. 16 in: *Challenging Inequities in Health. From Ethics to Action*, edited by T. Evans, et al. Oxford: Oxford University Press.



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